IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR SUPERIOR COUNTY

SPINE CARE DELAWARE, LLC.	)	
	)	
Plaintiff,	)	
v.	)	C.A. No. 04C-04-264-JEB
	)	
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,	)	
	)	
Defendant.	)	

Submitted: January 26, 2007
Decided: February 5, 2007

OPINION

Plaintiff's Motion for Summary Judgment.
Granted.

Appearances:

John S. Spadaro, Esquire.
Attorney for Spine Care Delaware.

Colin M. Shalk, Esquire, Thomas P. Leff, Esquire.
Attorneys for State Farm Mutual Automobile Insurance Company.

JOHN E. BABIARZ, JR., JUDGE.

Plaintiff Spine Care Delaware, LLC, has filed a breach of contract action against Defendant State Farm Mutual Automobile Insurance Company. Defendant provided Personal Injury Protection (PIP) insurance to numerous individuals who received medical treatment at Spine Care, a free-standing medical facility, for injuries sustained in automobile accidents. Following treatment at Spine Care, each individual received a bill for professional services with a separate charge for use of the facilities. This separate charge for use of the facilities is based on federal regulations relating to Medicare and Medicaid.[1] State Farm paid the bill for professional services but, in most instances, did not pay the facility fee, and this case is the result. As assignee of its patients, Spine Care alleges breach of contract, bad faith breach of contract and violation of Delaware's Consumer Fraud Act. It seeks compensatory damages and declaratory relief, as well as punitive damages. This opinion addresses Plaintiff Spine Care's motion for summary judgment on the issue of waiver of defenses to coverage for the facility fee.[2]

The parties agree to certain material facts. They agree that State Farm did not always respond to claims for coverage of facility fees within the 30-day time frame

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[1]42 CFR § 416.61.

[2]Plaintiff initially argued both waiver and estoppel but has abandoned the latter theory, which requires a showing of prejudice more than the trouble and expense of filing a lawsuit. *See One Virginia Avenue Condominium Assoc. of Owners v. Reed*, 2001 WL 1924195 (Del. Ch.); *Enoka v. AIG Hawaii Ins. Co., Inc.*, 128 P.3d 850, 871 (Haw. 2006).

set forth in Delaware's PIP statute.[3] They also agree that State Farm often denied coverage of the facility fee based on Spine Care's lack of a license to operate as a free-standing surgical facility.[4] State Farm has now abandoned the contention that the licensing question was a valid basis for denial of coverage. It now contends that the facility fee was not a reasonable or necessary medical expense.[5] Based on these facts, Spine Care argues that State Farm has waived the right to take any position other than the position taken within the statutory 30-day time frame. State Farm argues that the 30-day limit pertains only to claims the carrier finds to be covered and that there is no waiver of coverage defenses under Delaware PIP law.

When considering a motion for summary judgment under Superior Court Civil Rule 56, the Court's function is to examine the record to determine whether genuine issues of material fact exist.[6] If, after viewing the record in a light most favorable to the non-moving party, the Court finds there are no genuine issues of material fact,

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[3] *See, infra* p. 5.

[4] Spine Care has submitted evidence that it was not required to be licensed as a "free-standing surgical facility." The question, however, is not material to this discussion.

[5] Delaware's PIP statute requires payment of "reasonable and necessary" medical expenses. DEL. CODE ANN. tit. 21, § 2118(a0(2)a.

[6] *Oliver B. Cannon & Sons, Inc. v. Dorr-Oliver, Inc.*, 312 A.2d 322, 325 (Del. Super. 1973).

summary judgment is appropriate.[7]

The purpose of PIP insurance is to protect policyholders from the financial difficulties that can result from unpaid or overdue bills.[8] To achieve this purpose, the PIP statute imposes on insurance carriers specific obligations, as well as penalties for failing to comply with those obligations in a timely fashion. Under § 2118B(c) the following requirements apply. A carrier is required to pay a claim within 30 days of receiving a written request for payment with documentation for the treatment or expense. If a carrier denies payment of a claim or part of a claim, it must give the claimant a written explanation for the denial within 30 days of receiving the claim. Inherent in the requirement to provide an explanation is that the proffered explanation be the one actually relied on by the carrier in order to enable the insured to correct the problem or make an informed decision on whether to litigate as authorized in § 2118B(d).

The question before the Court is whether § 2118B(c) precludes a carrier from asserting a defense it failed to take during the statutory 30-day time frame. For the reasons explained below, the Court finds that the answer is yes. This result derives from the language of § 2118B (c) itself and is consistent with the purpose of PIP

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[7] *Id.*

[8] DEL. CODE ANN. tit. 21, § 2118B(a) (2005).

insurance as well as the public policy of this State.

Section 2118B(c) provides in part as follows:

> When an insurer receives a written request for payment of a claim for benefits pursuant to § 2118(a)(2) of this title, the insurer shall promptly process the claim and shall, no later than 30 days following the insurer's receipt of said written request for first-party insurance benefits and documentation that the treatment or expense is compensable pursuant to § 2118(a) of this title, make payment of the amount of claimed benefits that are due to the claimant or, if said claim is wholly or partly denied, provide the claimant with a written explanation of the reasons for such denial.

The parties address the statutory phrase "written explanation" in terms of whether it establishes a waiver of other defenses, which requires an unequivocal relinquishment of a known right, claim or privilege.[9] More accurately this is a question of preclusion, which applies to both an untimely response and also to a misleading explanation. That is, if a carrier fails to timely deny a claim, is it precluded from offering a defense to coverage in the course of litigation? And if the carrier offers one explanation for denial in the letter, is it precluded from defending its denial on a different ground during litigation? Any answer other than yes renders the requirements of § 2118B meaningless.

The statute yields little protection to policyholders if the carrier can ignore the request or offer one reason for denial only to change it when confronted with a

[9] *Burge v. Fidelity Bond & Mort. Co.*, 648 A.2d 414, 420 (Del. 1994).

lawsuit. Placing the burdens of accuracy and timeliness on the carrier is not unreasonable since it is the carrier who is the professional expert on insurance issues. This is the first time that this issue has been presented to a Delaware court. Not so in New York.

Under the New York PIP statute, a carrier must either pay or reject a claim within 30 days.[10] New York state courts have required strict compliance with the time limit, establishing a general rule that an untimely disclaimer prevents a carrier from raising a defense of lack of coverage at any later stage. One exception to this rule of preclusion is when a carrier asserts that the claimant's alleged injury does not arise out of an insured incident.[11] Another exception is when the insurance contract does not encompass either the vehicle or the incident.[12] Other than strict lack of

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[10] N.Y. Ins. Law § 5106 provides in part as follows:

(a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations. N.Y. Ins. Law § 5106. *See also* 11 NYCRR 65.15(g)(3).

[11] *Central General Hospital v. Chubb Group of Ins. Companies*, 681 N.E. 2d 413, 415 (N.Y. 1997).

[12] *Zappone v. Home Ins. Co.*, 432 N.E. 2d 783 (N.Y. 1982).

coverage grounds, the remedy of preclusion stands. For example, the exception is not extended to a carrier's defense that the treatment received was excessive.[13]

The Court finds that New York law is helpful in resolving the issue at bar because the New York PIP statute imposes the same obligations on carriers and because enforcement of those obligations is consistent with the purpose of PIP coverage in Delaware. The 30-day time frame is one way the General Assembly has chosen to avoid the "unjustifiable delay" in paying benefits that can cause financial hardship for policyholders.[14] In this case, each claimant received a bill from Spine Care for medical services or treatment which included a facility fee. State Farm has not asserted that there is a policy exclusion for a facility fee related to medical treatment, nor has it asserted that the insureds' injuries (and concomitant medical fees) did not arise from an insured incident or a covered vehicle. The Court holds that State Farm is precluded from asserting a coverage defense to claims for facility fees to which it did not respond within the statutory 30-day period set forth in § 2118B(c).

This principle also applies to inaccurate and unreliable responses. State Farm issued numerous denial letters based on a licensing issue which State Farm has

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[13] *Id.*

[14] *See* DEL. CODE ANN. tit. 21, § 2118B(a).

abandoned in hopes of now defending its denials on other grounds. The requirement that a written explanation be provided is meaningless unless the proffered explanation is correct. It is also meaningless if a carrier can offer a different defense at some later point. The Court concludes that a PIP carrier is precluded from shifting its position on defense of a denial after the 30 days expires. This conclusion is inherent within the statute itself and helps uphold the purpose of PIP coverage.

This outcome is unaffected by Defendant's remaining arguments. Defendant argues that waiver, or, as it turns out, preclusion of its other coverage defense results in a *de facto* broadening of coverage.[15] The Court finds otherwise. The facility fee was part of Spine Care's medical fees, and was presented as such, not as a separate bill unrelated to medical treatment. State Farm also argues that the 30-day limit begins to run only after the carrier receives documentation that the claim is compensable, and that it never received such documentation regarding the facility fee. However, State Farm paid the medical fee based on paperwork showing the type of treatment received as well as the date and time. State Farm was unable to identify what other information was pertinent to payment of the facility fee, and thereby acknowledged that the relevant documentation was provided.

For the reasons explained above, Plaintiff's motion for summary judgment is

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[15] *Enoka v. AIG Hawaii Ins. Co., Inc.*, 128 P.3d 850, 867 (Haw. 2006).

Granted.

It Is So ORDERED.

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Judge John E. Babiarz, Jr.

JEBjr/ram/bjw
Original to Prothonotary